SC

91021781

Local No. 3120-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST: Lucy MIDDLE: LAST: Porras
2 SEX: Female
3 DATE OF DEATH (Mo Day Yr): June 21,198
4 SOCIAL SECURITY NUMBER: 314-26-5743
5a AGE—Last Birthday (Years): 61
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Month Day Year): Mar 17,1928
7 BIRTHPLACE (City and State or Foreign Country): Temple, Texas
8 YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): Methodist Southlake Campus
9c CITY TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Manuel Porras
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b KIND OF BUSINESS/INDUSTRY:
13a RESIDENCE—STATE: Ind.
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Merrillville
13d STREET AND NUMBER: 9221 Clay St.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: No
13g ZIP CODE: 46410
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican etc.) ☐ No ☒ Yes Specify
15 RACE—American Indian, Black, White etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):

PARENTS

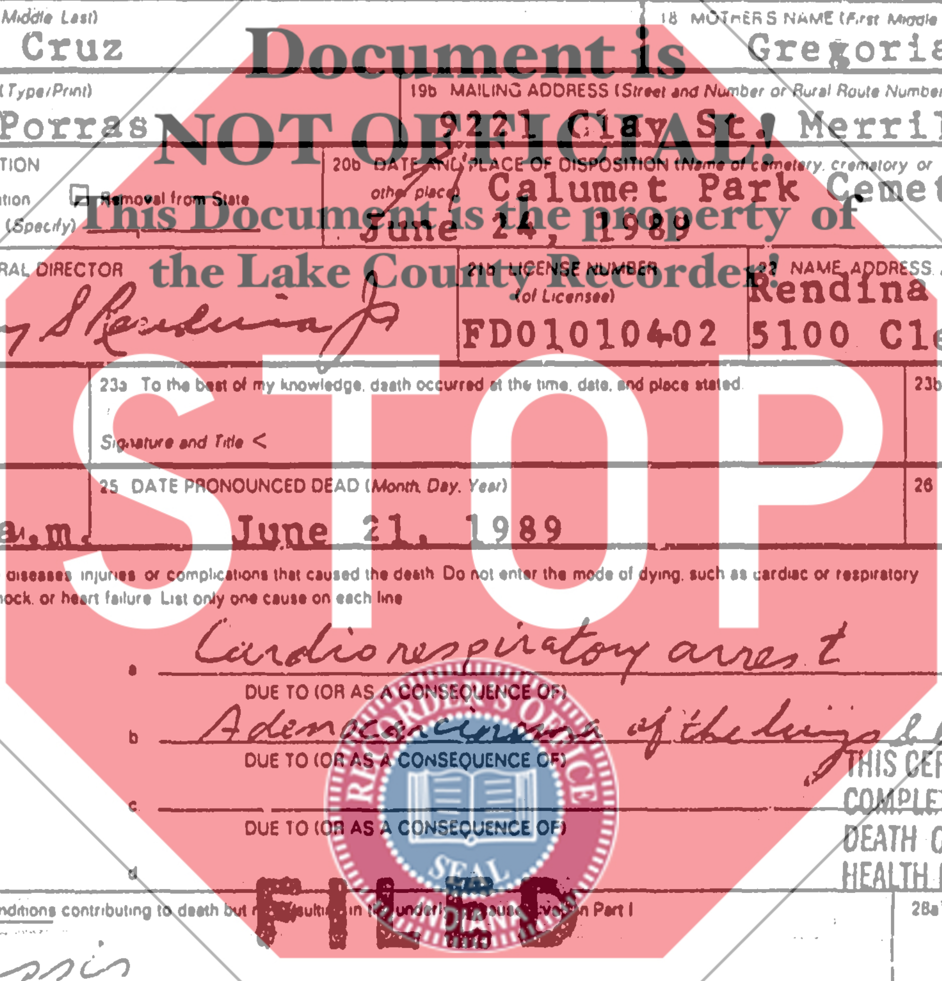
17 FATHER'S NAME (First Middle Last): Alvino Cruz
18 MOTHER'S NAME (First Middle Maiden Surname): Gregoria Maldonado

INFORMANT

19a INFORMANT'S NAME (Type/Print): Manuel Porras
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9221 Clay St. Merrillville, In
19c Relationship: Husband

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calumet Park Cemetery June 24, 1989
20c LOCATION—City or Town, State: Merrillville, Ind
21a SIGNATURE OF FUNERAL DIRECTOR: Anthony S Rendina Jr
21b LICENSE NUMBER (of Licensee): FD01010402
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Rendina F. Home FH83007819 5100 Cleveland St. Gary, In



PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <
23b LICENSE NUMBER
23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 7:35a.m.
25 DATE PRONOUNCED DEAD (Month, Day, Year): June 21, 1989
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiorespiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Adenocarcinoma of the lungs & liver
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Sepsis
28a WAS AN AUTOPSY PERFORMED? (Yes or no): JUN 23 1989
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

MAY 08 1991

CERTIFIER (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

Carl A. Johnson, M.D. LAKE COUNTY HEALTH COMMISSIONER
Recorder Lake County

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c LICENSE NUMBER: 01033620
29d DATE SIGNED (Month, Day, Year): 6/22/89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): IBRAHIM GEORGE ZABANEH, M.D. MERRILLVILLE HEALTH CENTER 6111 HARRISON ST. SUITE 215 MERRILLVILLE, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Carl A. Johnson
32 DATE FILED (Month, Day, Year): June 23, 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

00458

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1

Takes: 9221 Clay St., Crown Pt., In. 46307 Bl. 1 2.5 acres Deep River Reg # 15-204-5